City of Duluth

Human Resources
411 W. 1st Street #313
Duluth, MN 55802

Employee Status
☐ **Active** ☐ **Retiree**
☐ **Inactive**
☐ **Sub Group** _____

☐ **New Employee**
☐ **Change**
Effective Date:_____

Employee Data Maintenance Form (EDMF)

Name:_____ Social Security # _____
Last First Middle

Reason for change:

☐ Basic ☐ CDSA ☐ Leg & Ex

Department:_____ Division:_____ Unit: ☐ Fire ☐ Police ☐ Conf

Change of Name; Former Name:_____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐Single Birth date:_____

Address:_____

City, State, Zip:_____ Home Phone:(____)_____

Dependent Information:					Add/Remove	
Relationship	Name	Sex	Birth Date	SS #	Health	Dental

Are any of your dependents over age 19, attending school full-time, and not providing 50% or more of their own support? If so, complete a separate Student Information Request form for each dependent.

Emergency Contact Information:

Name	Relationship	Home	Work	Mobile #
1.				
2.				

Health Ins	Plan 1	Plan 2	Plan 3A	Plan 4	Dental Ins	Empl	Empl + Dep.	Family	COBRA
Single					$1000				
Family					$2000				
COBRA					Conf. Only $1500				

I wish the employer's contribution to go toward my ☐ family health insurance premiums ☐ deferred compensation plan.

Will you or any of your dependents be covered by any other health insurance or Medicare while under this coverage? ☐ Yes ☐ No
Name/Address of Insurance Company _____
Name(s) of Policy Holder(s) _____ Policy Number _____

I authorize the information or changes listed on this form as well as any necessary payroll deductions:

Employee Signature:_____**Date:**_____

For Office Use ONLY!! Distribution: Dental Health Personnel File Benefits Payroll

Health Group # **EP408-** __ __ | Dental Group # **000405-** __ __ __ __ | Fund: __ __ __ Agcy: __ __ __ Org: __ __ __ __

Data Entered by:_____ Date:_____ 20060331